STATE OF UTAH
DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING
APPLICATION FOR APPROVAL

PHARMACY PRECEPTOR

DOPL-AP-011 REV 06/11/2001

APPLICATION INSTRUCTIONS AND INFORMATION

General Statement: The Division desires to provide courteous and timely service to all applicants for approval. To maximize its efficiency and level of service, the Division will process complete applications only. **A complete application includes all applicable supporting documents.** Failure to complete the application and supply all necessary information may result in denial of licensure. Please read all instructions carefully.

Address of Record: The address listed on the application will be your address of record. All correspondence from the Division will be sent to that address. It is your responsibility to directly notify the Division of any change in address. Please note that the address of record is public information and is available upon request and via the internet. You may choose to use a business address or a P.O. Box for your address of record rather than your home address.

Social Security Number: Your social security number is classified as a private record pursuant to Title 63, Chapter 2, Utah Government Records Access and Management Act (GRAMA). It is used as an individual identifier for our licensing database and for purposes of the child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements the requirements of 42 U.S.C. 666(a)(13). An application that does not include a social security number is incomplete and cannot be processed.

Supporting Documents:

1. Submit documentation that you have engaged in active practice as a licensed pharmacist for not less than 2 years immediately preceding the date of this application.

   Using the "Request for Verification of License" form, obtain verification of licensure from the state in which you have been practicing for the last 2 years, if the state is other than Utah.

   Request that the verifying state(s) complete the form(s) and mail or fax them directly to the Division or return them to you for submission with your application.

Additional Important Information:

1. **Laws and Rules:** You are required to understand all Utah laws and rules pertaining to your practice as a pharmacist.

   The following applicable laws and rules are available on the Internet at http://www.commerce.state.ut.us/dopl/dopl1.htm.

   You may also purchase them for a fee from Experior, 5486 South 1900 West, Suite C, Taylorsville, Utah, 84118, (801) 355-5009.

   - Division of Occupational & Professional Licensing Act
   - General Rules of the Division of Occupational & Professional Licensing
   - Pharmacy Practice Act
   - Pharmacy Practice Act Rules
   - Utah Controlled Substances Act
   - Utah Controlled Substances Act Rules

2. You may obtain "The Internship Experience, A Manual for Pharmacy Preceptors and Interns" for a nominal fee from the Utah Pharmaceutical Association. You may contact them at (801) 762-0452.

3. The preceptor shall complete the preceptor section of the "Utah Pharmacy Intern Experience Affidavit" at the conclusion of the preceptor/intern relationship and provide that affidavit to the division.

Make Licensure Fees Payable To:

DOPL

Mail Complete Application To:

By U.S. Mail
Division of Occupational & Professional Licensing
P.O. Box 146741
Salt Lake City, Utah 84114-6741

By Delivery or Express Mail
Division of Occupational & Professional Licensing
160 East 300 South, 1st Floor Lobby
Salt Lake City, Utah 84111

Telephone Numbers:

Direct Dial: (801) 530-6623 or
(802) 530-6733

Utah Toll Free: (866) ASK-DOPL

(866) 275-3675

Fax Number: (801) 530-6511

APPLICATION FOR APPROVAL
PHARMACY PRECEPTOR

GENERAL INFORMATION

Social Security Number: _____

Last Name: _____Maiden Name:_____

First Name: _____Middle Name: _____

Do you currently hold a Utah license as a Pharmacist? Yes_____ No_____

If Yes, Utah Pharmacist License Number: _____ Date Granted: _____

Utah Controlled Substance License Number: _____

Gender (Male or Female):_____Date of Birth:_____

PUBLIC MAILING ADDRESS

Street:_____

City:_____State:_____Zip:_____

County:_____

Telephone:_(____)_____

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____

Date License/Certificate Approved:_____

Approved By: _____

Date License/Certificate Denied: _____

Denied By: ____

Reason For Denial/Other Comments: _________________________________

PROFESSIONAL LICENSES:

List all licenses, registrations, or certifications issued by any state, which you now hold or have ever held in pharmacy. Use additional sheets if necessary. If your two year experience requirement is not from Utah, send the applicable "License Verification" form to the Division from the state from which you are claiming the two year experience requirement.

Issuing State: _____

Profession:_____

Issuing State: _____

Profession:_____

PHARMACY PRACTICE SITE(S) AT WHICH YOU WILL ACT AS A PRECEPTOR (Use additional sheets if necessary):

Name of Pharmacy:_____

Address of Pharmacy:_____

Name of Pharmacist-In-Charge:_____

Pharmacy License Number: _____ Phone Number:_____

EXPERIENCE AS A LICENSED PHARMACIST:

Answer AYes@ or ANo@

_____I am currently employed as a professional experience program coordinator in an accredited pharmacy school.

_____I have engaged in active practice as a licensed pharmacist in Utah for not less than 2 years immediately preceding the date of this application.

_____I have engaged in active practice as a licensed pharmacist in _____ (list state) for not less than 2 years immediately preceding the date of this application.

Please list your experience as a Pharmacist for the past 2 years. Use additional sheets if necessary.

1. Employer:_____Phone:(____)_____

Address:_____

Dates of Employment: From_____/_____To _____/_____ Contact Person:_____

Position and Duties:_____

2. Employer:_____Phone:(____)_____

Address:_____

Dates of Employment: From_____/_____To _____/_____ Contact Person:_____

Position and Duties:_____

3. Employer:_____Phone:(____)_____

Address:_____

Dates of Employment: From_____/_____To _____/_____ Contact Person:_____

Position and Duties:_____

CONTINUING EDUCATION:

Attach documentation that you have met the requirements for qualified continuing education for the two years prior to your last license renewal. Specify the time frame covered and include applicable certificates of participation.

"THE INTERNSHIP EXPERIENCE"

Answer AYes@ or ANo@

_____I have studied "The Internship Experience", A Manual for Pharmacy Preceptors and Interns, August 1980 and will utilize it to assist me in providing a meaningful experience for pharmacy interns.

AFFIRMATION OF INTENT TO PERFORM AS A PRECEPTOR:

I declare that I understand the current Utah Pharmacy Practice Act and the Rules of the Utah Board of Pharmacy. I understand that while I may supervise more than one intern, I may supervise only one intern actually on duty in the practice of pharmacy at any one time. I will maintain adequate records to demonstrate the number of internship hours completed by the intern and an evaluation of the quality of

the intern's performance during the internship. I will complete the preceptor section of the "Utah Pharmacy Intern Experience Affidavit" at the conclusion of the preceptor/intern relationship regardless of the time or circumstances under which that relationship is concluded and provide it to the division. I also understand that I am responsible for the intern's acts related to the practice of pharmacy while practicing as a pharmacy intern under my supervision. I subscribe to and will abide by the Code of Ethics of the American Pharmaceutical Association. I am willing to employ an intern and I will supervise the intern utilizing as a guide for his/her training, the Preceptor-Intern Guide developed by the Tripartite Committee representing the Utah Pharmaceutical Association, the State Board of Pharmacy, and the University of Utah College of Pharmacy.

Signature of Preceptor Applicant:_____ Date:_____

IF PHARMACY IS OWNED BY OTHER THAN THE APPLICANT, THE FOLLOWING MUST BE SIGNED:

I hereby certify that I am willing to have the herein named applicant serve as a Preceptor and will permit him/her to employ an intern in my pharmacy.

Owner of Pharmacy:_____

Signature of Pharmacy Owner:_____ Date:_____

PHARMACIST QUALIFYING QUESTIONNAIRE

Answer "yes" or "no" for each question. Do not leave any question blank.

1. _____Have you ever applied for or received a license, certificate, permit or registration to practice in a regulated profession under any name other than the name listed on this application?

2. _____ Have you ever been denied the right to sit for a licensure examination?

3. _____Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?

4. _____Have you ever been permitted to resign or surrender your license, certificate, permit or registration to practice in a licensed profession while under investigation or while action was pending against you by any professional licensing agency or criminal or administrative jurisdiction?

5. _____Are you currently under investigation or is any disciplinary action pending against you now by any professional licensing agency?

6. _____Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?

7. _____Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility or criminal or administrative jurisdiction?

8. _____Is any action pending against you now by either the federal Drug Enforcement Administration or any state drug enforcement agency?

9. _____ Have you been named as a defendant in a malpractice suit? The filing date of the complaint naming you as a defendant should be considered to be the date of the malpractice suit for purposes of responding to this question.

10. _____Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?

11. _____If you are licensed in the health care profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or

welfare because of any circumstance or condition?

12. _____Are you currently using or have you recently (within 90 days) used any drugs (including recreational drugs) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?

13. _____Have you ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law, for which you have not successfully completed or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?

14. _____Have you been arrested for or charged with a misdemeanor or felony charge in any jurisdiction during the last 10 years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.

15. _____Have you ever pled guilty to, no contest to, or been convicted of any felony or misdemeanor in any jurisdiction?

If you answer yes to question 14 or 15 you must include with your application a copy of the police report, court docket, and any probation/parol officer report for EACH and EVERY arrest and/or conviction within the past ten years.

16. _____Have you ever been involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?

17. _____ Have you ever been terminated from a position because of drug use or abuse?

18. _____ Have you ever been incarcerated for any reason in any Federal, State or County Correctional Facility?

If you answered "yes" to any of the above questions, please enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

A "yes" answer does not necessarily mean that you will not be granted a license, however, additional documentation may be requested by the Division if the information submitted is insufficient.

AFFIDAVIT and RELEASE AUTHORIZATION

I am the applicant described and identified in this application for licensure, certification, or registration in the State of Utah.

I am qualified in all respects for the license, certificate, or registration for which I am applying in this application.

To the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, misrepresentation, or omission of material fact.

To the best of my knowledge, the information contained in the application and its supporting document(s) is truthful, correct, and complete; and, discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Division in conjunction with this application or its supporting documents meets the same standard as set forth above.

I understand that it is unlawful and punishable as a class A misdemeanor to apply for or obtain a license or to otherwise deal with the Division or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

I understand that this application will be classified as a public record and will be available for inspection by the public, except with regard to the release of information which is classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

I authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

Signature of Applicant:_____

Date of Signature:_____

Printed Name of Applicant: _____

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Division of Occupational and Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
FAX: 801-530-6511

REQUEST FOR VERIFICATION OF LICENSE

TO BE COMPLETED BY THE APPLICANT:

Request that the verifying state complete the form and mail or fax it directly to the Division or return it to you for submission with your application

Applicant Name: _____

Street Address: _____

City: _____

State:_____ Zip: _____

I am requesting licensure in the State of Utah as a _____

I am/have been licensed in your State under the name _____

My Social Security Number is _____

My Date of Birth is _____

My license number in your State is/was _____

I have enclosed the necessary license verification fee in the amount of $ _____

Signature of Applicant: _____

TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested, sign and verify the document, and mail or fax it directly to the Division or place the completed form in an envelope, seal the envelope and provide it to the applicant in person or by mail. The applicant will include the verification of licensure with his/her Utah application. Thank you.

Name of Verifying State: _____

Name of Licensee (as it appears in verifying state's records): _____

Classification of License Issued:_____

License Number: _____

Current Status: _____

Original Date of Licensure:_____

Expiration Date: _____

Continuously Licensed:

_____Yes _____No, please elaborate_____

Licensed By:

_____Exam, Type:_____Date: _____

_____Endorsement, From What State: _____

Examination Scores:_____

Education Required For Licensure:_____

Disciplinary Action or Pending Disciplinary Action:

_____No _____Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: _____

Title:_____

Agency:_____

Date: _____

(SEAL)